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Department of Health and Human Services

FOR DISCUSSION
DRAFT
PURPOSES ONLY

MaineCare

Value-Based Purchasing Strategy

Tribal Consultation

January 23, 2012

http://www.maine.gov/dhhs/oms/vbp

Agenda

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Agenda

- Welcome & Introductions
- Overview of DHHS Value-Based Purchasing Strategy
- Medical Homes and the PCMH Pilot
- Health Homes
- Accountable Communities Initiative

Overview of Value-Based Purchasing Strategy

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Value-based purchasing means holding providers accountable for both the quality and cost of care, through:

- Increased transparency of cost and quality outcomes
- Reward for performance
- Payment reform

The Department has developed a three-pronged Value-Based Purchasing strategy to achieve target savings and improved health outcomes.

1. Emergency Department Collaborative Care Management Initiative
2. Leveraging of current initiatives and federal opportunities
   - Health Homes
   - Primary Care Provider (PCP) Incentive Payment Reform
   - Transparency and Reporting
3. Accountable Communities Initiative

Value Based Purchasing Timeline to Date

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Feb 2011:

Suspension of Maine Managed Care Initiative (MMI)

Aug 2011: Announcement of VBP Strategy

Oct 2011:

Stakeholders reconvened to introduce VBP Strategy

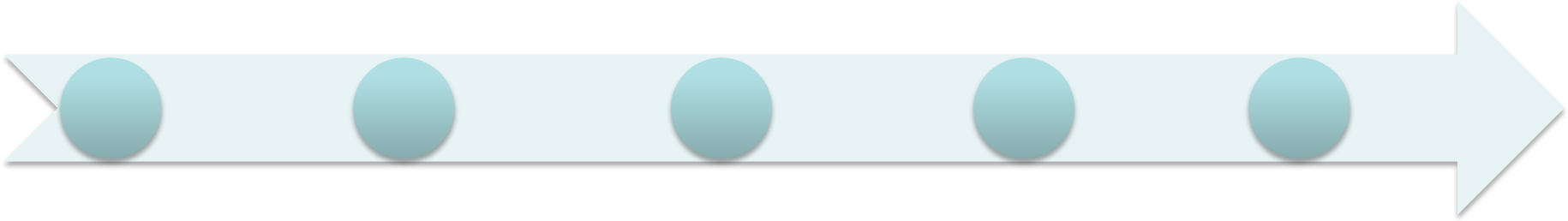
Member Standing Committee Reconvened

Nov 2011:

Request for Information (RFI) Issued

Dec 2011:

28 RFI responses received



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Medical Homes

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Medical Homes are primary care practices that:

- Care for members using a team approach to care coordination.
- Focus on a long term relationship between member and PCP.
- Have electronic medical records.
- Have open access scheduling and convenient hours.

Medical Homes in Maine:

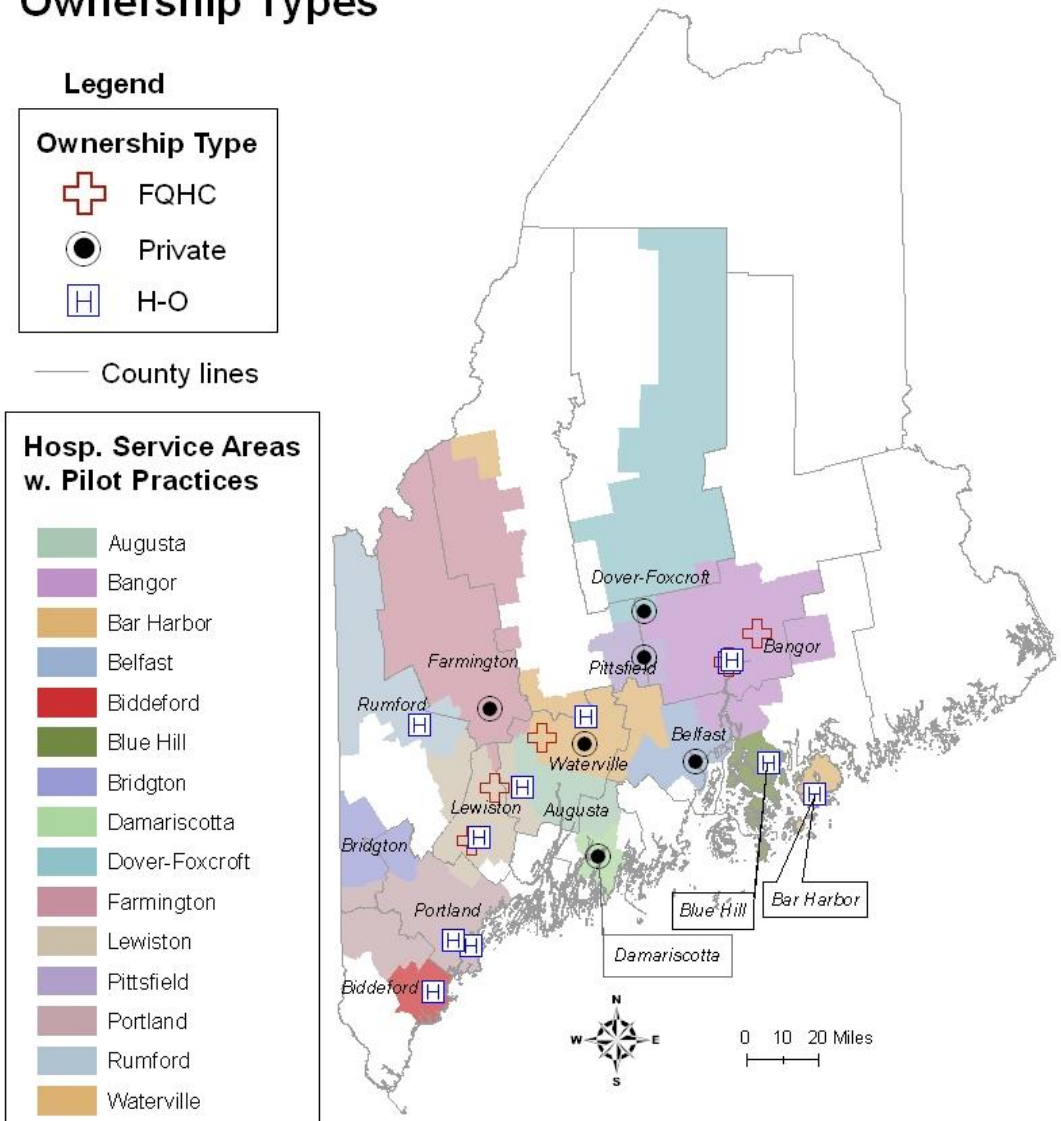
- Maine has 26 practices engaged in a multi-payer Patient Centered Medical Home Pilot. This multi-payer pilot will expand by 20 practices in January 2013.
- In total, there are 82 practices recognized as Medical Homes by the National Committee for Quality Assurance (NCQA).
- In addition, 14 Federally Qualified Health Centers (FQHCs) have been selected as part of CMS's Advanced Primary Care demonstration. These practices must attain NCQA certification within the next year.

Defining Medical Home Model

"A **medical home** is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective."

- American Academy Pediatrics (1964)

Maine PCMH Pilot Practices
Ownership Types



Maine PCMH Pilot
Practice "Core Expectations"

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT

Phase 2 Pilot Expansion

- 20 new adult practices to be selected for participation in multi-payer Pilot
- Expectations:
  - Strong leadership for change
  - NCQA PCMH recognition (Level 1 or higher)
  - Fully implemented EMR
  - Commitment to implement Pilot Core Expectations

2. Leveraging Current Initiatives: Health Homes

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Medical Homes

Community Care Teams (CCTs)

- Medicare joined the multi-payer PCMH pilot this month as part of Medicare's Multi-Payer Advance Primary Care Practice (MAPCP) grant that Maine received.
- As part of the MAPCP demo, Maine has implemented eight Community Care Teams that will work with the PCMHs to coordinate and connect the highest need patients to additional healthcare and community resources.
- The 20 additional practices to join the PCMH pilot in January 2013 must also connect with a new or existing CCT to serve their patients.

Community Care Teams

- Multi-disciplinary, community-based, practice-integrated care teams
- Build on successful models (NC, VT, NJ)
- Support patients & practices in Pilot sites, helping patients overcome barriers to care, improve outcomes
- Key element of cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (ED use, admits)

ME PCMH Pilot CCTs

- Androscoggin Home Health
- Coastal Care Team (Blue Hill FP, Comm Health Cntr/MDI, Seaport FP)
- Community Health Partners (Newport FP, Dexter FP)
- DFD Russell
- Eastern Maine Homecare
- Kennebec Valley (MEGenl)
- MMC
- PCHC

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2. Leveraging Current Initiatives: Health Homes

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Medical Homes

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Community Care Teams (CCTs)

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Health Homes

- Medical home practices and the CCTs together enable MaineCare to better serve our highest need populations and qualify for the Affordable Care Act's "Health Home" State Plan option.
- CMS will provide a 90/10 match for Health Home services to eligible members for eight quarters.
- The 90/10 match will enable MaineCare to pay care management fees for any MaineCare members that meet CMS' chronic conditions criteria, including members dually enrolled in MaineCare and Medicare, and members enrolled in hospital-based practices.

2. Leveraging Current Initiatives: Health Homes

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Health Homes may serve individuals with:

- Serious and persistent mental illness (SPMI)
- Two or more chronic conditions
- One chronic condition and who are at risk for another

- Required Health Home services include:
  - Comprehensive care management
  - Care coordination and health promotion
  - Comprehensive transitional care from inpatient to other settings
  - Individual and family support
  - Referral to community and social support services
  - Use of health information technology (HIT)

- MaineCare plans to serve individuals with SPMI in the second phase of its Health Homes initiative, through the partnership of medical home practices with Community Mental Health Center CCTs.

2. Leveraging Current Initiatives: Health Homes Timeline

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Feb 2012:

PCMH Pilot Expansion/ Health Home RFP posted by Quality Counts

Mar 2012:

Submit Health Homes State Plan Amendment (SPA)

PCMH/ Health Homes applications due

May 2012:

Practices selected

CCT application released

July 2012:

SPA approval for implementation

CCT application deadline

Aug 2012:

New CCTs selected

Jan 2013:

Implementation for members with SPMI

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3. Accountable Communities: What is an ACO?

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The definition of an ACO depends on who you ask…

The Department is adopting the simple definition that an ACO is:

An entity responsible for population's health and health costs that is:

- Provider-owned and driven
- A structure with a strong consumer component and community collaboration
- Includes shared accountability for both cost and quality

2. Accountable Communities: How is an ACO different from a MCO?

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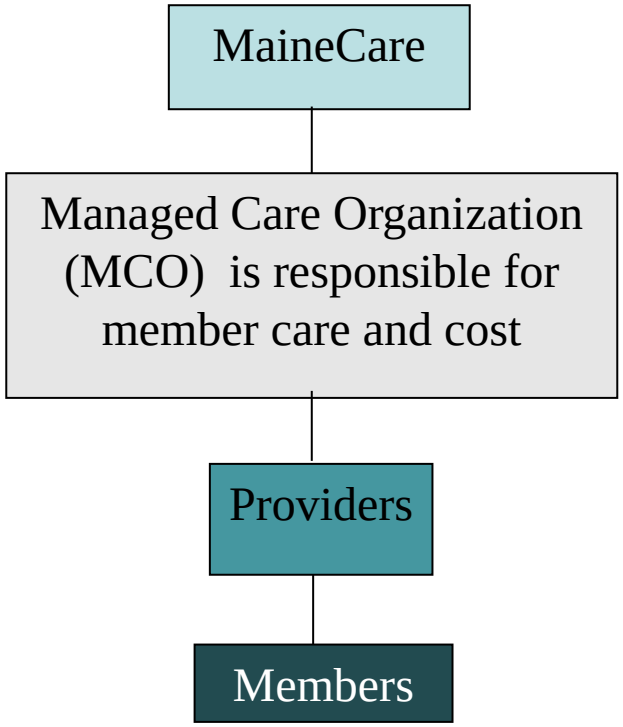
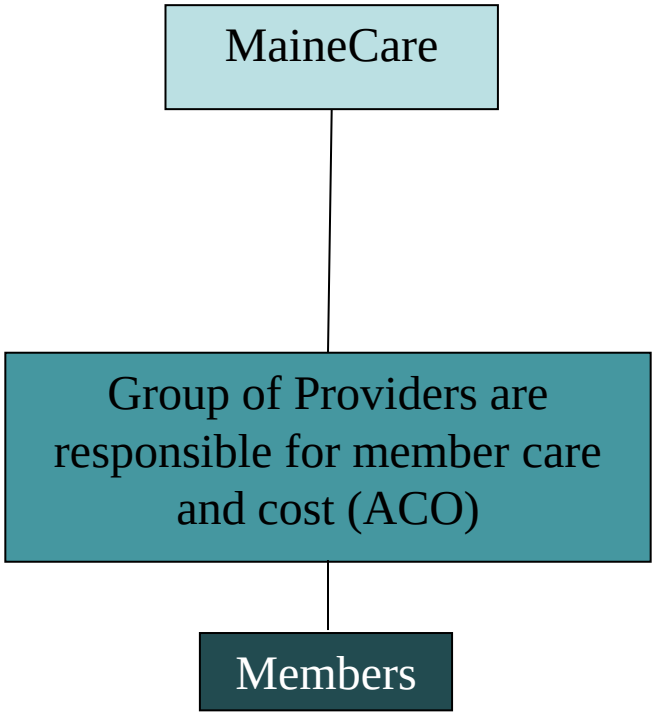
Managed Care Organization (MCO)



Accountable Care Organization (ACO)



2. Accountable Communities: How is an ACO different from Managed Care?

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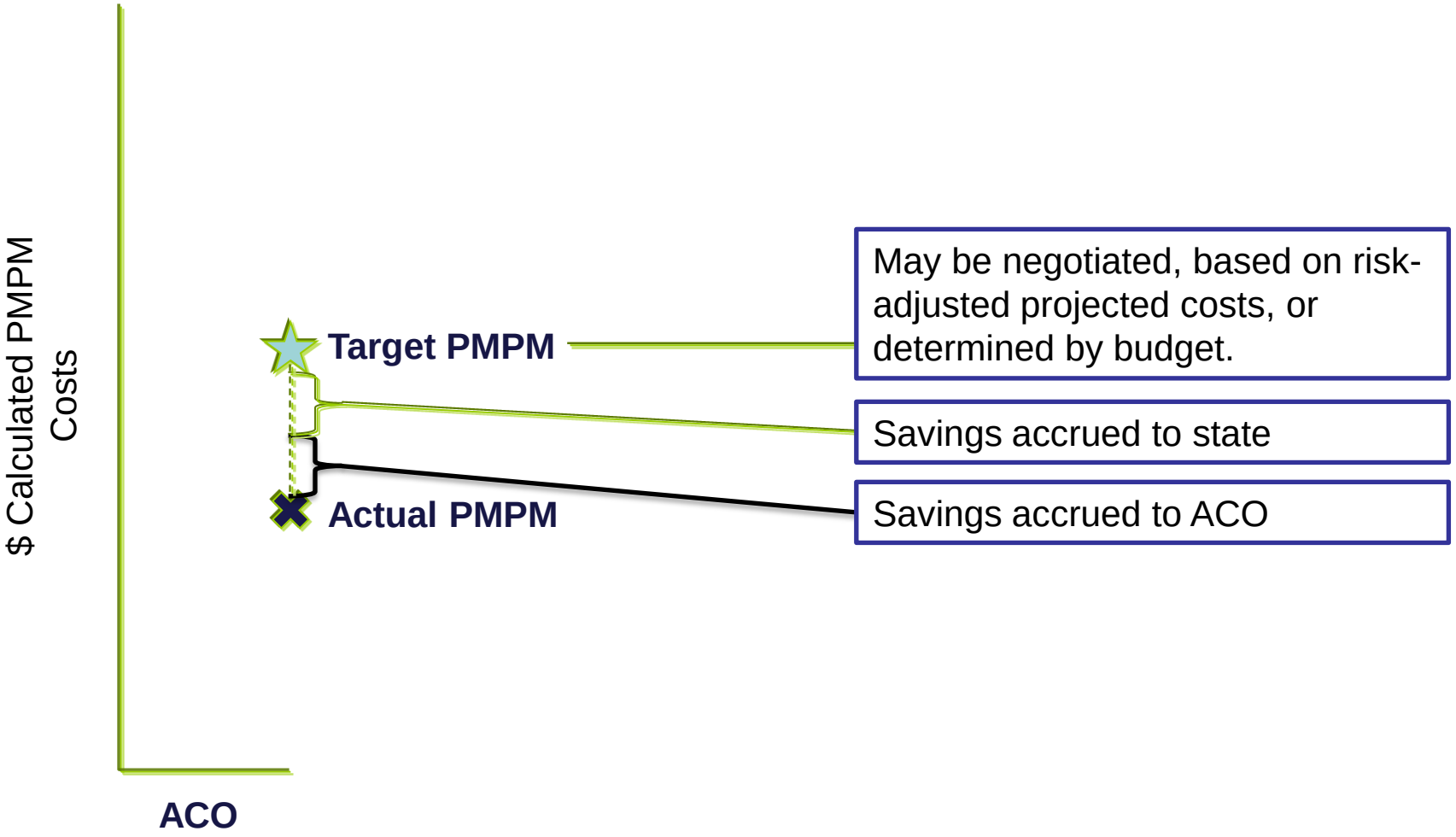
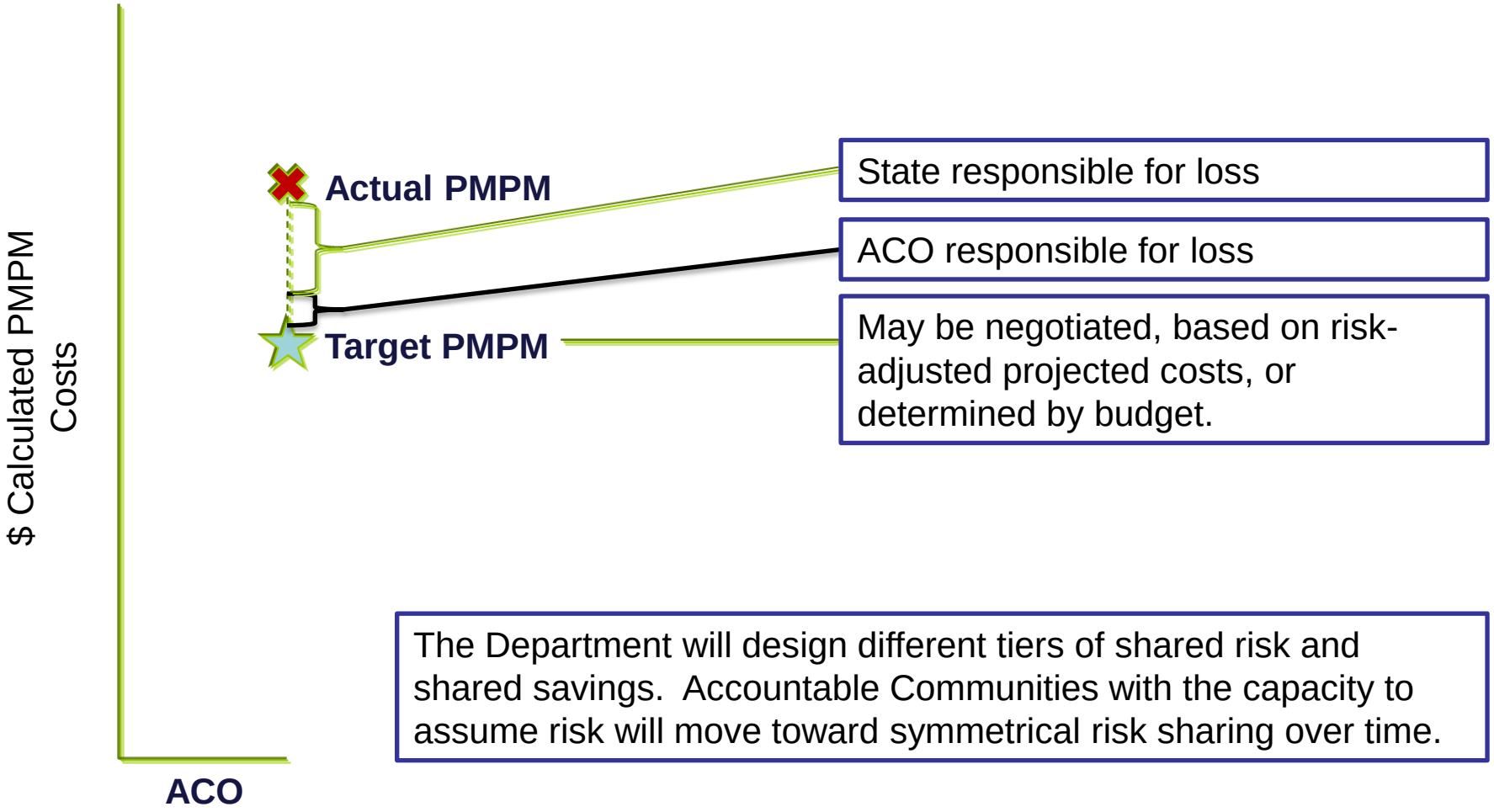
Managed Care Organization (MCO)	Accountable Care Organization (ACO)
Have traditionally controlled costs through utilization and rate control	Major levers to control costs are care coordination across providers and collaborative approach with member.
Members enroll in MCO Health Plan	Members are "attributed" to an ACO based on where they already receive their care.
Member choice of providers is limited to providers in MCO network	Members retain choice of providers with an emphasis on development of a relationship between ACO providers and the member.

2. Accountable Communities: Will start with a shared savings model



2. Accountable Communities: Over time, some communities will assume shared risk.



The Department will design different tiers of shared risk and shared savings. Accountable Communities with the capacity to assume risk will move toward symmetrical risk sharing over time.

2. Accountable Communities: MaineCare's Basic Model Components

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- Open to any willing and qualified providers statewide
  - Qualified providers will be determined through an RFP or application process
  - Accountable Communities will not be limited by geographical area
- Members retain choice of providers
- Alignment with aspects of other emerging ACOs in the state wherever feasible and appropriate
- Flexibility of design to encourage innovation

To serve the unique needs of the MaineCare population:

- Requirement that Accountable Communities collaborate with other providers, hospitals, and social service organizations in the community
- Focus on integration of physical and behavioral health
- Strong interest in proposals to serve highest need populations

2. This group will finalize many other details of the Accountable Communities design with RFI input.

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What providers make up an ACO?

- Will mandate the inclusion of PCP and collaboration with community health and social service organizations
- Otherwise remain flexible re membership.

For which costs and services will Accountable Communities be responsible?

MaineCare plans to define a “core” set of services for which all Accountable Communities will responsible. Accountable Communities will be encouraged to assume responsibility for additional services beyond the core. MaineCare is interested in proposals to serve the highest need populations.

How will an Accountable Community know for which members it is accountable?

MaineCare currently plans to attribute members based on their assigned PCCM PCPs. Members who are not in PCCM would be assigned prospectively based on the PCP that received a plurality of their visits in the past..

Accountable Communities Timeline

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Mar 2012:
Public Forum to present proposed model

May 2012:
Release Application
Submit SPA

Oct 2012:
Implementation

How do the different components of the VBP Strategy fit together?